U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 21Dec2000

Case Nos..: 1999-LHC-752/ 1999-LHC-2569

OWCP Nos.: 14-115699/ 14-130930

In the Matter of:

KAREN ALDRIDGE,
Claimant

against

DEPARTMENT OF THE ARMY,
Employer

APPEARANCES:

JAMES M. HACKETT, **ESQ.**
On behalf of the Claimant

DEIDRE D. FORD, ESQ.
On behalf of Employer

BEFORE: RICHARD D. MILLS
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This is a claim for benefits under the Longshore and Harbor Worker's Compensation Act (hereinafter "the Act"), 33 U.S.C. § 901, et seq., brought by KAREN ALDRIDGE ("Claimant") against DEPARTMENT OF THE ARMY ("Employer") for injuries allegedly sustained in the course and scope of her employment as a child care worker at the U.S. Army installation at Fort Wainwright.

The issues raised here could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. A formal hearing was held July 27, 2000 at Anchorage, Alaska.

STIPULATIONS

Prior to the hearing, the parties agreed to a joint stipulation (JX-1):[1]

> 1. The Claimant was injured on the following dates: October 9, 1991, October 19, 1992, January 21, 1994, February 23, 1994, and February 6, 1996;
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> 2. Except for the injuries in February of 1994 and February of 1996, the Claimant missed no time from work as a result of her injuries;
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> 3. Each of the injuries listed occurred within the course and scope of the Claimant's employment;
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> 4. An employer/employee relationship existed between Claimant and Respondent at the time of these injuries;
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> 5. The Employer was advised of the injuries on the following dates: October 9, 1991, October 20, 1992, January 24, 1994, February 23, 1994, and February 6, 1996;
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> 6. The Employer filed a notice of controversion for each injury on the following dates: November 10, 1994, December 21, 1994, April 25, 1995, January 27, 1998;
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> 7. The parties have held several different informal conferences both by telephone and by mail;
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> 8. Claimant's pre-injury average weekly wage was $261.10;
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> 9. The Claimant was Temporarily totally disabled for various periods, and compensation was paid by the Employer for each period in an amount totaling $9529.60 for all periods;

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[1] The following references will be used: TX for the official hearing transcript; JX-__ for Joint exhibits; CX-__ for the Claimant's exhibits; and RX-__ for Employer's exhibits.

10. The Employer has paid benefits for medical treatment and continues to pay for medical treatment except for past and on-going pharmacy bills as noted;

11. The Claimant reached maximum medical improvement from her injuries on January 30, 1996, February 29, 1996, September 9, 1997, and January 29, 1998 respectively.

ISSUES

The parties also listed the following specific issues as unresolved:

1. Temporary total disability payments for the Claimant for various periods;

2. Claimant's past and ongoing permanent and total disability and associated benefits;

3. Whether Employer filed Amended Application for Limitation under Section 8(f) constitutes a statement and an admission pursuant to 29 CFR part 18.801(a) and 29 CFR parts 18.801 (d) (2) (i), (ii), (iii), or (iv), as to claimant's permanent and partial disability;

4. Claimant's request for reasonable attorney's fees and costs.

SUMMARY OF FACTS

I. Claimant's Employment

The Claimant, Karen Aldridge, worked for the Child Development Center (CDC) at Ft. Wainwright in Fairbanks, Alaska. She was a program assistant at this facility. Her employment started in June of 1991 and ended when her disability prevented her from carrying out her duties in April of 1996. (TX, p. 21). The claimant's work history prior to her employment with the respondent is detailed in her handwritten notes attached to her deposition and discussed at trial. (CX-6, p. 119 et seq.) (TX, p. 20-22).

The Ft. Wainwright CDC is a government facility managed by a non-appropriated funds instrumentality. All of its employees are employees of this instrumentality. (JX-1). Claimant had a series of injuries while working for this organization. (JX-1, TX, p. 22). The Claimant testified that she was released from her position at Ft. Wainwright following the last of these injuries because she could not

perform her normal daily activities. She explained that she could not sit for more than 30 minutes, and could not walk or stand for more than 15 minutes without the pain becoming unbearable. She said she could not think straight or sleep and that she was constantly taking medication. (TX, p. 23). As a result of these limitations, her supervisor, Marlis Evans, told her that the CDC did not have any work for her. (TX, p. 23).

II. Claimant's Injury and Medical Treatment

This case involves multiple injuries to the same Claimant incurred in the course and scope of the same job. Each injury in turn exacerbated the harm caused by the previous injuries. The final injury is the most significant with respect to the Claimant's disability, accordingly, we treat it first.

The Claimant was ultimately relieved of her position at the CDC following her accident on February 6, 1996. That day, the Claimant was walking into the kitchen area of one of CDC's rooms with a baby in her arms when she slipped on some of the over-spray[2] on the floor and fell. (TX, 40). She testified that she fell on the floor with the baby in her arms. According to the Employer's report of the incident she landed on her left hip and elbow, jolting her spinal area and aggravating her previous lower back and neck injuries. (TX, 40-41). She explains that the Employer therefore was aware that this injury had aggravated her previous lower back and neck problems. (TX, 41).

Following her fall in February of 1996, Claimant continued to work. Her physician at that time, Dr. Unsicker, wrote a letter indicating that she was to be placed on limited duty. (TX, 41). She testified that from that point on every time she injured her spine it caused her entire lower back and neck to hurt. (TX, 41-2). She testified that she had signed a statement indicating that she would not see a doctor for this injury because she was already being treated.[3] The Employer knew that she was already being treated. (TX, 42).

According to Aldridge, when she was working with infants, she was responsible for their daily care. She was often responsible for working with children from infancy up to 5 years of age. According to her testimony, she was eventually switched to working entirely with the infants because the management of the CDC thought that they would be less rowdy than the 5 year olds. (TX, 42-3). Claimant explained that she had difficulty working with the infants because doing so required her to change them. She asked if she could do so on a mat on the floor, but was told that she could not. This meant that, in order to change the

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[2]Claimant testified that the over-spray was bleach water that was used to clean the tables and that had been sprayed onto the floor in the process. (TX, 40).

[3]The full text of that statement read "I, Karen Aldridge, elected not to see a physician at this time due to the fact I'm already seeing a physician for injuries sustained in a previous on-the-job injury." (TX, 41; CX-1, p. 21).

infants, she had to lift them onto the changing table. Inevitably, the problem with this was that lifting even the smallest children hurt her back. (TX, p. 43-4). In fact, Claimant testified that when she goes to the grocery store, lifting a gallon of milk causes severe back pain. As a consequence, she tries to avoid lifting anything anymore. (TX, 44).

We note that in the interests of keeping the Claimant's testimony short, and because she was not able to remain on the stand for a long period, both direct and cross examination were abbreviated. The Court therefore has gleaned its understanding of the Claimant's medical condition from her medical records related to this accident. Most of these medical records are contained in the Employer's Exhibit A, with a few supplemental records contained in Claimant's Exhibit 10.

It appears from the medical records that Dr. James Jardine was the Claimant's treating physician with respect to her injuries in both February of 1994 and February of 1996. Following her accident on February 23, 1994, Claimant was seen by Dr. Jardine, a Fairbanks, AK chiropractor. Dr. Jardine indicated in his medical records that the Claimant had been thrown into a wall by her students during a fire drill. This accident injured the Claimant's left shoulder and her neck. Dr. Jardine opined in the notes of his first visit with the Claimant that this had aggravated her pre-existing workplace injury. He treated her with spinal manipulation and physical therapy. (EX-A, p. 291).

Dr. Jardine filed his next physician's report on March 1, 1994. In that report, he indicated that the Claimant had suffered an additional exacerbation of her back condition due to her injury in February of 1994. (EX-A, p. 288). Dr. Jardine was continuing a treatment at the time that involved spinal manipulation, physical therapy, exercise, and neuromuscular re-education. (EX-A, p. 288).

The following day, Dr. Jardine indicated that the Claimant was suffering from cervical whiplash with resulting spinal dysarthria and associated acute cephalgia. He indicates that the Claimants chief complaint was of acute and recurrent headaches. At the time he was continuing the Claimant's treatment with physical therapy and manipulations as before. (EX-A, p. 285). By the end of March, Dr. Jardine had sent the Claimant to massage therapy for her injuries. The treatment that followed this referral is detailed in the notes of Jan Jackson, a massage therapist with Natural Balance Massage. (EX-A, p. 281). The records of the Claimant's massage therapy indicate continuing complaints of neck pain and lower back pain. (EX-A, p. 281). Doctor Jardine's first report following the beginning of her therapy indicated that the claimant's "condition is steadily improving." (EX-A, p. 280).

The records reflect continued steady improvement on Claimant's part following the beginning of massage therapy. Doctor Jardine continued to send the Claimant for massage therapy, and to see her for spinal manipulations, as well as exercise, and neuromuscular re-education. His report of May 4, 1994 indicates that the Claimant continued to improve with the help of this therapy. (EX-A, p. 276). The improvement continued until June of 1994 when Dr. Jardine noted that the patient's work routine lead to intermittent exacerbations of her existing back injuries. (EX-A, p. 273). Despite the presence of these intermittent exacerbations, Dr. Jardine observed that the patient continued to improve through the

application of spinal manipulation, physical therapy, and exercise, his previously recommended course of treatment. (EX-A, p. 271).

During July of 1994, Claimant participated in an independent medical examination. (EX-A, p. 269). By the beginning of August the Claimant was generally improving. She continued to suffer, however, from periodic headaches and lower back pain. Doctor Jardine treated the Claimant through the same methods he had used before. (EX-A, p. 268).

During the period that Claimant was treating for this injury, she was also participating in the national breast implant litigation. As a part of this litigation she underwent a medical examination performed by Dr. Steven Overman of Seattle, Washington. Doctor Overman reported the findings of his examination of the Claimant and her medical records in a letter to the Claims Administrator for the breast implant case in August of 1994. (EX-A, p. 244). As a result of the exam, Dr. Overman found that the Claimant had "Atypical Connective Tissue Disease.[4]" (EX-A, p. 245). Because Dr. Overman's evaluation does not give specific information about the disease, however, we cannot determine whether it is related to the Claimant's present problems.

About this time, the Claimant began to consult with Dr. Carl Unsicker about her problems. Dr. Unsicker originally diagnosed the Claimant with chronic cervical degenerative disc disease as exacerbated by a cervical strain. Doctor Unsicker also determined that the Claimant had suffered a lumbar strain. The narrative report indicates that all of the Claimant's conditions were improving and that they would require an additional 3-6 months of physical therapy or chiropractic treatment. Dr. Unsicker thought that the Claimant could return to her regular work position and that she would not suffer permanent disability. (EX-A, p. 242).

Medical records indicate that the Claimant's condition continued to improve through October of 1994. At that time, Dr. Jardine explained that she continued to suffer from intermittent exacerbations which were related to her work stress. (EX-A, p. 235). One of the exacerbations mentioned by Dr. Jardine apparently happened during the first week of November and caused lower back pain radiating to the Claimant's left leg. By November 1, 1994 the symptoms of this condition were improving and Dr. Jardine

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[4]Atypical connective tissue disease is one of a variety of disorders of musculoskeletal and connective tissues. *See The Merck Manual*, 16th Ed. 1992. Dr. Overman does not indicate that the Claimant suffers from a particular form of the disease acknowledged in the medical literature. (EX-A, p. 245). We therefore have no basis for determining either 1) whether this disease is in fact related to the Claimant's back; or, 2) whether this is a pre-existing condition with respect to the Claimant's workplace injuries.

thought that the claimant would be in remission within one month. (EX-A, p. 231). On November 4, 1994 Dr. Jardine wrote an open letter indicating his treatment of the Claimant and that she should not lift, twist, bend, or sit for long periods as any of those activities might seriously endanger her health. (EX-A, p. 230). Doctor Jardine also listed these restrictions in his attending physician's report to OWCP dated November 17, 1994. (EX-A, p. 227-8). He issued a narrative report letter describing the Claimant's symptoms and her history of treatment to Mr. Ron Cook of Alexis on that same day. (EX-A, p. 224).

Subsequent to the issuance of restrictions by Dr. Jardine, the Claimant's supervisor, Marlis Evans, wrote a "Memorandum for the Record."[5] (EX-A, p. 220). This memorandum, dated November 29, 1994, noted the letter from Dr. Jardine indicating that the Claimant should not lift, twist, bend or sit for extended periods. It also explained that the listed functions were essential components of working at the CDC at Ft. Wainwright. Based upon these factors, Evans therefore declined to allow the Claimant to return to work without a clearance statement from her physician. (EX-A, p. 220).

On December 5, 1994, Dr. Jardine stated in his physician's report that the Claimant was continuing to improve after her most recent exacerbation. He felt that conservative care in the future would prevent the need for surgical intervention. (EX-A, p. 219). At this point, Dr. Jardine also apparently referred the Claimant to the Fairbanks Psychiatric and Neurological Clinic for evaluation. (EX-A, p. 217).

Doctor James Foelsch of the Fairbanks Psychiatric and Neurological Clinic performed certain diagnostic tests on the Claimant and issued an opinion on December 12, 1994. This doctor performed a variety of Electrophysiologic tests and a complete Neurological examination. He indicates that the results of these tests were normal. Based on his tests, Dr. Foelsch opined that the Claimant suffered from chronic low back pain with no evidence of radiculopathy. (EX-A, p. 213-4).

Doctor Jardine returned the claimant to work on December 21, 1994. He indicated that she could lift up to 40 pounds, but that she should not do so on a regular basis. A handwritten note on Dr. Jardine's letter indicates that Claimant actually returned to work on December 22. (EX-A, p. 212).

Claimant's progress continued essentially unchanged through the beginning of March of 1995. At that time she saw Dr. Unsicker in follow-up. Doctor Unsicker's examination notes from March 6, 1995 indicate that the Claimant was suffering from a lumbar strain and perhaps a lumbar disc. He specifically heard her complain of increasing discomfort in her lower back with radiation into her legs. (EX-A, p. 207). On the basis of the Claimant's complaints, Dr. Unsicker ordered an MRI. (EX-A, p. 206). Doctor Fuzzard of the Denali center in Fairbanks read the results of the MRI and determined that the claimant showed signs of the dessication of the intervertebral disks at the L4-5 and L5-S1 levels. Based on these

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[5]The Court notes that this memorandum appears in the medical records of the Claimant despite the fact that it is not, on face, a medical record. We do not treat this as medical evidence. Instead, we discuss it here as background regarding the effect of the Claimant's treatment on her occupation.

images he diagnosed the Claimant with symmetrical posterior disk bulging at both levels. (EX-A, p. 204).

Based on the MRI and the physical examination of the patient, Dr. Unsicker decided that he would continue conservative treatment of the Claimant without surgery. He explained in his March 21, 1995 notes that the normal neurologic examination and the general toleration of the symptoms without extremes indicated this course of treatment. (EX-A, p. 203). In June of 1995 Dr. Unsicker was forced to return the Claimant to physical therapy because she had again exacerbated her prior injury. According to his notes, the Claimant had recently been switched back to working with older children and this had caused the exacerbation. (EX-A, p. 203).

In April of 1995, Dr. Patricia Conners-Allen[6] performed an independent medical evaluation of the Claimant's condition. This medical evaluation was limited to the records only along with a synopsis of the Claimant's treatment prepared by the insurance carrier. (EX-A, p. 199). Dr. Allen's opinion was that the Claimant was slipping into chronic pain syndrome and that Dr. Jardine's treatment of her was excessive. (EX-A, p. 200).

The Claimant continued to participate in a course of physical therapy prescribed by Dr. Unsicker until August 4, 1995. At that point she stopped going to therapy. Doctor Unsicker wrote a letter to Mr. Gomez of Alexsis on August 18, 1995 indicating that the Claimant would soon reach maximum medical improvement and could return to work. He suggested that the Claimant would do better working with smaller children and should be generally restricted from lifting significant amounts of weight. Doctor Unsicker also opined that the Claimant might require further medical care including occasional medication and/or continuing physical therapy. He believed that surgery would not be needed based on her current situation. (EX-A, p. 181). In February of 1996, Dr. Unsicker wrote a letter to Mr. Akinlana of OWCP indicating that, because the Claimant suffered from degenerative disc disease aggravated by the duties of her current job, she should be retrained for a position that did not require lifting, bending, twisting, or turning. (EX-A, p. 178).

Doctor Unsicker indicated that the Claimant had reached maximum medical improvement in a letter dated February 29, 1996. He suggested in that letter that the Claimant should continue with her permanent restrictions. His final diagnosis was lumbar and cervical degenerative disc disease aggravated by her work situation. (EX-A, p. 177).

Within a few weeks after Dr. Unsicker issued this opinion, the Claimant suffered her 1996 accident. She fell while carrying a baby in the cafeteria of the CDC. This again aggravated her condition, and she contacted Dr. Unsicker for treatment. Unsicker was now of the opinion that the Claimant should be temporarily restricted to sedentary work and that she should be limited from carrying more than 3 to 5

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[6]Dr. Conners-Allen is a Chiropractor working for CorVel Corporation.

pounds on a repetitive basis. (EX-A, p. 176).

By July of 1996, Claimant had changed physician's and was seeing Dr. Lindig. Doctor Lindig agreed with the diagnosis listed by Dr. Unsicker that the Claimant was suffering from degenerative disc disease in both the lumbar and cervical spine. He concluded that because of this condition she was not able to return to her regular work. (EX-A, p. 172).

In September of the following year, Dr. Lindig issued a narrative report of the Claimant's treatment and condition. In this report he stated that she was totally incapacitated for any kind of gainful employment and that she could not even attend classes at the university. Although Dr. Lindig had previously reviewed a number of job analyses submitted to him as possible alternate employment for the Claimant and approved them, he wrote that the passage of time had now indicated that she would be unable to perform even that work. (EX-A, p. 143-4).

Doctor Lindig continued to follow the Claimant's progress with her back pain. He remained of the opinion that she could not work and that her symptoms did not indicate surgery for her back pain. He continued to follow the same course of conservative treatment. Doctor Lindig did recommended that the Claimant consider having a series of epidural steroid injections. He stated that she was probably not a candidate for a lumbar laminectomy at this time. (EX-A, p. 124).

Subsequent to these recommendations, the Claimant was subjected to yet another Independent Medical examination by the employer's chosen orthopedic surgeon, Dr. Ron Brockman. Doctor Brockman agreed with the diagnosis provided by Dr. Unsicker. He opined, however, that the claimant had not suffered an aggravation of her pre-existing condition. He also agreed that she had reached maximum medical improvement as of February 29, 1996, the date selected by Dr. Unsicker. He further opined that she was capable of returning to work at her regular employment and that she should not lift more than 20 pounds. Dr. Brockman's IME was dated December 20, 1997. (EX-A, p. 116-127).

Doctor Lindig disagreed with Dr. Brockman's suggestion that the Claimant could return to work. Over the course of additional evaluations, he determined that the claimant had continuing symptoms of this problem and that she was experiencing "good days" and "bad days." He indicated that the possibility of her returning to her regular employment was poor. (EX-A, p. 104).

At this point, the insurance company began to refuse to pay for the Claimant's further treatment. Citing the opinion rendered by Dr. Brockman regarding this claimant, the insurer declined to pay for the medications prescribed by Dr. Lindig. Lindig meanwhile reasserted his contention that the Claimant had not recovered and that she needed continuing physical therapy and other treatment. He provided the Claimant with office samples of Arthrotec 75 and instructed her to try them. (EX-A, p. 99).

By the 19th of March, 1998, Claimant was taking up to 12 tablets of aspirin per day. She could not tolerate the use of NSADs to relieve her pain. Dr. Lindig noticed that she had limitation of motion in

both her cervical and lumbar spine. He also noted tenderness and spasm in both areas as well as other physical problems. (EX-A, p. 95).

The bulk of the Claimant's medical records at this point reflect continuing pain and suffering related to her back problems that is better on some days and worse on others. Dr. Lindig has continued to treat the claimant for her symptoms through conservative medical treatment and the use of pain medications where appropriate. Doctor Lindig also responded to CorVel's request regarding their additional labor analyses. He indicated that any of the positions that CorVel proposed were inappropriate given the Claimant's work and capacity restrictions. (EX-A, 58-63; EX-A generally).

When Dr. Lindig made arrangements to retire in March of 1999, he referred the Claimant to either Dr. Becker or Dr. Simpson who specialized in spine surgery. (EX-A, p. 42). On April 13, 1999, Claimant consulted with Dr. Cobden[7] regarding her problem. Doctor Cobden fully evaluated the Claimant's current condition. He determined that the Claimant was suffering from chronic lumbar pathology and that she had probably herniated a disc at the L5-S1 level. (EX-A, p. 39-40).

Doctor Cobden determined that the current symptoms were probably radiating from the area of the Claimant's May 1993 injury, but he noted that the results of the MRI were inconclusive. He ordered a dexascan to assess the amount of localized osteopenia. (EX-A, p. 39-40).

On July 14, 1999 the Claimant was seen by Dr. Douglas Smith[8] in Anchorage for an additional IME. Doctor Smith examined the Claimant and reviewed her medical records from her prior treatment. Doctor Smith diagnosed the Claimant with multilevel degenerative disk disease causing chronic neck and lower back pain. He also identified a possible disc protrusion and atypical connective tissue disease apparently related to her bilateral breast implants. Smith indicated that while the Claimant probably had degenerative disc disease before 1991 based on the available x-rays, he could not be certain. He also could not be certain if her exposure to the industrial hazards of her position exacerbated the problem. (EX-A, p. 23-4). Doctor Smith stated that there was no specific medical treatment that he was aware fo that would help the Claimant to improve her level of function. (EX-A, p. 26). He felt that the Claimant was not a candidate for surgical intervention. (EX-A, p. 27).

Since Dr. Smith performed his IME, the Claimant has continued with treatment under Dr. Cobden's care. Cobden has tried pain management, exercises, epidural injections and all manner of other modalities to relieve the Claimant's pain. None of these options has been entirely successful. The Claimant had a final IME from Dr. Bald dated November 13, 1999. This IME, however was done from the Claimant's medical records alone. Dr. Bald opined that the claimant was employable and that the soft tissue workplace injuries did not have any evidence of being related to the Claimant's constant complaints related to her degenerative disc disease. (EX-A, p. 6-12). Since this time, the Claimant's condition remains essentially unchanged.

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[7]Cobden is an Orthopedic Surgeon with Tanana Valley Clinic in Fairbanks, AK.

[8]Doctor Douglas Smith is an Orthopedic Consultant. (EX-A, p. 18).

DISCUSSION

I. Jurisdiction

The parties have not contested jurisdiction in this case. The Claimant was injured while working as a civilian employee at Ft. Wainwright. The parties agree that such injuries are covered by the Nonappropriated Fund Instrumentalities Act, 5 U.S.C. § 8171 et seq., 5 U.S.C. § 2105. We agree and render findings of fact and conclusions of law consistent with that jurisdiction.

II. Claimant's Prima Facie Case

Causation

The Court finds based on the stipulations of the parties and the evidence in the record that the Claimant has made a prima facie showing of causation sufficient under the Longshore and Harbor Worker's Compensation Act (the Act). The parties have stipulate that the Claimant was injured in the course and scope of her employment on 5 different dates. (JX-1). They do not dispute that an employer/employee relationship existed between the Claimant and the Respondent at the time of each and every one of these injuries. (JX-1). The employer admits that it was informed of each and every one of the Claimant's injuries and that it filed notices of controversion as appropriate. Finally, the Employer acknowledges that it has paid temporary total disability benefits to the Claimant, compensated her for her medical expenses, and other costs since her departure frm their services. (JX-1).

There is no dispute that the Claimant was injured at various times during her employment with the U.S. Army. The question is which of the injuries contributed to her disability if any. The Act gives us a specific mechanism for dealing with this type of claim. That mechanism is the section 20(a) presumption. Under this section, if the Claimant shows that she suffered harm because of work conditions or a work accident that could have caused, aggravated, or accelerated the condition, she is entitled to a presumption that her disability is causally related to her employment. *See* 33 U.S.C. § 920(a); *see also Gencarelle v. General Dynamics Corp.*, 22 BRBS 170 (1989), *aff'd*, 892 F.2d 173, 23 BRBS 13 (CRT) (2d Cir. 1989).

In this case, we think that the Claimant has clearly met her burden to invoke the presumption. Claimant and Employer stipulate that the Claimant was hurt. (JX-1). They further stipulate that a workplace accident occurred.[9] (JX-1). We find that, considering all of the medical evidence, there is

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[9]In fact, they stipulate to workplace accidents occurring on October 9, 1991, October 19, 1992, January 21, 1994, February 23, 1994, and February 6, 1996. (JX-1). The Court believes based on the medical evidence that there might well be other accidents, more minor than these, which the parties do not list. Doctor Cobden, for example suggests that there was a May 1993 injury that aggravated the

sufficient evidence to conclude that the accidents in question were sufficient that they could have caused, aggravated, or accelerated the Claimant's condition. Although some of the IME evidence in this case questions the truth of this statement, none says that it is an absolute impossibility. The Court therefore finds that the Claimant is entitled to the presumption that her injury is causally related to her employment.

Given this finding, Employer's burden is to prove that the Claimant's disability is not causally related to the workplace injury. *See James v. Pate Stevedoring Co.*, 22 BRBS 271 (1989). Employer proposes to this end that Claimant's disability is actually the result of her progressive degenerative disc disease. *Emp. Brief* at 17. To that end, Employer offers a number of independent medical opinions.

In the first independent medical opinion, Dr. Bald asserts that the Claimant's symptoms are entirely the result of her pre-existing degenerative disc disease and are unrelated to her workplace accidents. We decline to accept Dr. Bald's conclusions, however, because he did not actually examine the Claimant or perform any of his own diagnostic tests. Bald reached his conclusion on the basis of medical records alone, and we therefore discredit his opinion. (*See* EX-A, p. 6-12). For the same reasons, we decline to accept the conclusions listed in Dr. Allen's evaluation of the Claimant. (EX-A, p. 199-200).

In contrast to Drs. Bald and Allen, Dr. Smith of the Anchorage Medical and Surgical Clinic performed a full examination and review of the Claimant's case. Although this visit was a one time IME, Dr. Smith took reasonable diagnostic steps in the performance of that IME including examining the Claimant in person. Following his examination Dr. Smith concluded that both the degenerative disc disease and the workplace accidents might contribute to the Claimant's current disability. He indicated, however, that it was impossible to tell to what extent each had contributed. (EX-A, p. 18-27).

Finally, the independent evaluation by Dr. Brockman was relied upon by the Employer and Carrier in terminating Claimant's original benefits and medical treatment. Doctor Brockman concluded on the basis of his examination of the Claimant that she could return to work in December of 1997. He suggested that the Claimant had not actually aggravated a pre-existing condition. He also proposed that, upon returning to work, the Claimant limit her lifting to 20 pounds. The Court notes that the Claimant was employed as a childcare worker. This position, by her supervisor's own admission, requires frequent lifting, bending, twisting, and stooping. (EX-A, p. 220). By nature, a child care worker is expected to pick up her charges and comfort them. In our opinion, only the youngest children will weigh less than 20 pounds. These children must be changed on a table, requiring constant lifting by the care giver. (TX, p. 43-4). The Court concludes that Dr. Brockman's opinion is based on a grave misunderstanding of the Claimant's

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Claimant's condition and required his treatment. (EX-A, p.39-40).

employment. The misunderstanding is so severe in our mind as to render the medical opinion unusable.

The problems with the various medical opinions offered by the Employer, combined with the uncertainty of their doctors regarding whether the Claimant's condition is the result of a pre-existing condition or workplace injury, or both, prevent us from finding that the Employer has met its burden. At best, the evidence shows that the Claimant might not have a work related disability. The Court has carefully weighed all of the evidence and finds that the Claimant's injury is undeniably causally related to her workplace injuries.

Compensability

This Claimant has suffered multiple workplace injuries on her way to her present condition. In addition, the Employer suggests that she suffers from at least on pre-existing condition which is the primary cause of her disability. Employer offers medical evidence which appears to suggest that the Claimant suffers from both Atypical Connective Tissue Disorder[10] and degenerative disc disease[11]. Employer argues that we should follow one of two alternative paths. Either the Claimant should not be entitled to compensation because her injury is not work related, or the Employer is entitled to relief under section 8(f) because she had multiple injuries and pre-existing conditions. This represents the sum total of Employer's controversy over this claim. We disagree with Employer's first argument, but agree with respect to the second.

We have already determined that the Claimant's condition is causally related to her workplace injuries. In doing so, we have also concluded that Employer fails to show that a pre-existing condition is entirely responsible for this disability. The only remaining question is whether the fact that this condition is the result of multiple injuries or partially due to a pre-existing condition makes it non-compensable.

The law is clear that if the Claimant suffers a work-related injury that aggravates, exacerbates, accelerates, contributes to, or combines with a previous infirmity, disease, or underlying condition, the entire resultant condition is compensable. *See Wheatley v. Adler*, 407 F.2d 307 (D.C. Cir. 1968). Further, if the second injury aggravates the claimant's prior injury, thus further disabling the claimant, the second injury is the compensable injury, and liability therefor must be assumed by the employer or carrier for whom the claimant was working when "reinjured." *See Strachan Shipping Co. v. Nash*, 782 F.2d 513, 18 BRBS 45 (CRT) (5th Cir. 1986) (en banc), *aff'g*, 15 BRBS 386 (1983); *Abbott v. Dillingham Marine & Mfg. Co.*, 14 BRBS 453 (1981), *aff'd mem. sub nom. Willamette Iron & Steel Co. v. OWCP*, 698 F.2d 1235 (9th Cir. 1982).

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[10](EX-A, p. 244-45).

[11](EX-A, p. 315).

Based on the medical evidence, we believe that the Claimant's several injuries at the CDC either aggravated each other or aggravated her degenerative disc disease or both. The end result of these injuries is her current, disabled condition. We apply the "aggravation rule" developed by the Fifth Circuit in *Strachan*, which holds that the entire resultant disability is compensable without regard to the relative contributions of the workplace injury and the pre-existing condition. *See Strachan*, 782 F.2d at 513.

Nature and Extent

Employer does not argue the nature and extent of the Claimant's disability despite terminating her compensation and providing medical evidence that she can return to work.[12] There are two tests for determining whether a Claimant's disability is permanent in nature. The first allows us to conclude that a Claimant's disability is permanent when the claimant has reached maximum medical improvement and retains some residual disability. *See James v. Pate Stevedoring Co.*, 22 BRBS 271, 274 (1989); *Phillips v. Marine Concrete Structures*, 21 BRBS 233, 235 (1988); *Trask v. Lockheed Shipbuilding and Construction Co.*, 17 BRBS 56, 60 (1985). The second allows us to conclude that the Claimant's disability is permanent when it has continued for a lengthy period and appears to be of lasting and indefinite duration. *See Watson v. Gulf Stevedore Corp.*, 400 F.2d 649, 654 (5th Cir. 1968), *cert. denied*, 394 U.S. 976 (1969).

In this case, we need not reach the second test. Doctor Unsicker found that the Claimant had reached maximum medical improvement (MMI) as of February 29, 1996. (EX-A, p. 177). This date is almost one month after her final stipulated date of injury of February 6, 1996. The Court finds that on the basis of this medical opinion, the Claimant has reached MMI, that she continues to have residual disability, and that this residual disability may be considered permanent.

Alternatively, even if the Claimant had not reached MMI for her February 6, 1996 accident, she would meet the second test. The Claimant's current condition extends from the present day back to at least her February of 1996 injury and perhaps earlier. While earlier manifestations of this problem got better with physical therapy and other treatments, her current symptoms show no signs of improvement. (*See generally* EX-A). The Court finds that a four year struggle with no end in sight is a lengthy enough period to justify the conclusion that the Claimant's condition is permanent.

To establish that the extent of her disability is total, the Claimant must establish that she cannot return to her former employment. *See Elliot v. C & P Tel. Co.*, 16 BRBS 89 (1984). This standard

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[12]*See* EX-A, p. 104, p. 122.

applies whether the claim is for temporary or permanent total disability. Once the Claimant has met her burden she is presumed totally disabled. *See Walker v. Sun Shipbuilding & Dry Dock Co. (Walker II)*, 19 BRBS 171 (1986). A physician's opinion that the Claimant's return to her prior work would aggravate her condition is enough for us to determine that her disability is total. *See Care v. Washington MATA*, 21 BRBS 248 (1988).

Here, the Claimant's medical records, offered in full as Employer's exhibit A, show without a doubt that the Claimant cannot return to her former employment. The considered medial opinion of Drs. Cobden and Lindig, Claimant's treating physicians is that returning to work as a child care assistant would aggravate the Claimant's condition. The evidence reflects that her supervisor has gone on record saying that the functions she cannot perform are vital to her position. We discredit

the opinions of the independent medical examiners to the contrary for the reasons given herein. The Court therefore finds that the Claimant cannot return to her former employment. As such, Claimant is entitled to the presumption that her disability is total.

A finding that the Claimant's disability is presumptively total shifts the burden to the Employer. Employer then must prove the availability of suitable alternate employment. *Clophus v. Amoco Prod. Co.* 21 BRBS 261 (1988). Employer in this case does not even begin to press that issue. Although Employer sent a lists of proposed alternate employment to Claimant's doctors on two different occasions, it is clear that none of these positions are suitable given her condition. Specifically, Dr. Lindig reviewed a set of proposed positions in February of 1999 and determined that they were not suitable because "she is not physically fit for any type of gainful employment that I can think of at this time." (EX-A, p. 57 *et seq.*). Doctor Lindig had also reviewed a set of proposed jobs in July of 1996 and approved some of them as work that the Claimant could perform. (EX-A, p.165-171). In September, 1997, however, he reviewed those proposed positions and indicated that the Claimant was not capable of them. He said, "elapsed time has well demonstrated that she would probably have been unable to perform even [sedentary] work." (EX-A, p. 143).

Only Dr. Brockman suggests that the Claimant is employable. He also reviewed a series of proposed positions in February of 1999 and opined that the Claimant was capable of performing them. (EX-A, p. 48-53). We have previously declined to consider Dr. Brockman's independent medical examination because his failure to consider the nature of Claimant's employment made his conclusion suspect. Certainly this is also reason to decline to review his job recommendations. Even if it were not, however, we find that the Claimant could not perform the positions Brockman approved. The position with Guardian Security required frequent standing and walking. (EX-A, p. 48). Claimant testified at trial that even a brief walk to the Court that morning had caused her pain so severe she had to leave the hearing to lie down. (TX, p. 19). The position as a security agent with Alaska Airlines required frequent standing, occasional walking, and frequent lifting of carry-on bags weighing up to 50 pounds. (EX-A, p. 49). Beyond the obvious difficulties with walking and standing, we find that the lifting requirements of this

position are incompatible with the condition of a Claimant who testified that the pain is so bad she tries to avoid lifting even a gallon of milk. (TX, 44). Likewise, the position as a receptionist with the Tanana Valley Clinic is inappropriate because it requires the Claimant to remain seated and requires a great deal of lifting. (EX-A, p. 50). The position at the Fairbanks Princess Hotel is inappropriate because it would require the Claimant to stand constantly, bend, stoop, and lift. (EX-A, p. 51) Her treating physician has determined that she can do none of these. The same is true of both the Payless Car Rental and the Pizza Bella positions. (EX-A, p. 52-3).

Doctor Brockman's assertion that the Claimant could perform functions which a short period in the court room demonstrated she is incapable of underscores our concern about his IME. It also demonstrates that there is likely not suitable alternate employment for the Claimant. It would be unwise of the Court to substitute the judgment of a doctor who evaluated the Claimant for 15 minutes (TX, p. 47) for that of one who saw her throughout her treatment. The Court therefore finds that

there is no suitable alternate employment available to the Claimant given her condition. This requires a further finding that the Claimant is totally disabled.

Based on the preceding findings, the Court finds that the Claimant is entitled to benefits for permanent total disability from the Date of Maximum medical Improvement and continuing. In addition, she is entitled to compensation for her past and on-going medical care, including prescription medications.

III. Section 8(f) Relief

The Employer's final assertion is that the Claimant's pre-existing condition should entitle it to relief under section 8(f) of the Act. 33 U.S.C. § 908 (f); *Emp. Brief* at 20 *et seq.* Employer asserts as the underlying injury for this purpose, the Claimant's previous workplace injuries at the CDC. *Emp. Brief* at 20-1. Employer stipulated prior to trial, however, that the Claimant did not miss any work as a result of her previous injuries. (JX-1). In fact, the record clearly indicates that she returned to work after all but the February of 1994 and February, 1996 injuries.

An employer can claim the benefits of section 8(f) relief when 1) the claimant had an existing permanent partial disability that, 2) contributed to her permanent total disability, and 3) the existing permanent partial disability was manifest to the employer prior to the injury that is the basis for this claim. *See Director OWCP v. Cargill, Inc.*, 709 F.2d 616, 619 (9th Cir. 1993). This relief is designed to avoid discrimination against handicapped workers. For that reason, it is specifically made available when the work-related injury combines with a pre-existing partial disability to result in greater permanent disability than the injury alone would have. *See Lockheed Shipbuilding v. Director, OWCP*, 951 F.2d143, 1144, 25 BRBS 85, (CRT) (9th Cir. 1981).

Here the Court has trouble determining whether the Claimant suffered from a pre-existing

permanent partial disability. The Court has waded through the medical records offered by the Employer in proof of their assertion. There is certainly evidence in the Claimant's medical records that she may have had a pre-existing difficulty with her back. In 1992, Claimant's chiropractor, Dr. George Allen, treated her for her 1991 workplace injury. His narrative report indicates that the Claimant suffers from "pre-existing degenerative cervical disease." This pre-existing condition in Dr. Allen's opinion, means that the Claimant will not be able to completely heal after injuring her back. She will therefore not be able to return to her pre-accident status. (EX-A, p. 315).

The Claimant's degenerative disc disease was also noted by Dr. Unsicker in 1996. (EX-A, p. 178). He explained that the Claimant's persistent problems had lead him to order an MRI of her spine. The scan indicated bulging discs at the L4/5 and L5/S1 levels. This lead Dr. Unsicker to conclude that the Claimant suffered from degenerative cervical and lumbar disc disease. (EX-A, p. 178). According to his records, this condition is aggravated by repetitive bending, twisting, turning, and heavy lifting. (EX-A, p. 178). The Benefits Review Board has previously found that degenerative disc disease, caused by aging, can be a pre-existing partial disability. *See Greene v. J.O. Hartman Meats,* 21 BRBS 214, 216-18 (1988).

The Court thinks that the most appropriate analysis is one with respect to multiple workplace injuries in which we engage above. *Supra* at 13-14. An injury compensable under that schema is also subject to 8 (f) relief where it combines with a pre-existing disability to make the Claimant's condition worse than it would have been. In this case, it is likely that the Claimant's employment and injuries contributed to make her disability worse than it otherwise would be. Disability under 8(f) is now a broad enough term that it covers those cases where an existing physical disability would motivate a cautious employer to discharge the employee because of the risk of workplace accidents. *See C & P Tel. Co. v. Director, OWCP (Glover)*, 564 F. 2d 503, 513 (D.C. Cir. 1977).

In this case, the Court finds that the Employer had constructive notice of the Claimant's degenerative condition. This constructive knowledge is evidenced by the medical records that were present at the time of the injury, specifically, Dr. Allen's 1992 report and Dr. Unsicker's 1996 opinion. *See Director, OWCP v. Universal Terminal and Stevedoring, (De Nichilo)*, 575 F.2d 452, 457, 8 BRBS 498 (3d. Cir. 1978). The available medical evidence was sufficient to motivate the cautious employer to discharge Ms. Aldridge for fear that she might be involved in further work-place accidents. *See Topping v. Newport News Shipbuilding and Drydock Co.*, 16 BRBS 40, 43-44 (1983).

Employer has given us medical records from the Claimant's involvement in breast implant litigation, her regular annual check-ups, mammograms, colds, flus, and other exams we need not mention here. The Court has slogged through all of them. The Court finds that there is medical evidence that the Claimant had complications related to her silicone breast implants. The Court also finds that the Claimant suffers from degenerative disc disease. Though the connection between this latter condition and the Claimant's disability are tenuous, we find that there is enough evidence to suggest that the Claimant's work-place injury or injuries may have made her condition worse than it otherwise would be. Doctors Lindig and Unsicker both limited the Claimant to sedentary work and lifting not more than 3 to 5 pounds on a repetitive basis. Finally,

Dr. Lindig removed the Claimant from work entirely in July of 1996. (EX-A, p. 172). The Court finds that the medical report issued by Dr. Lindig in September of the following year is persuasive in its claim that the passage of time has shown the Claimant to be totally incapacitated for any kind of work. This opinion was based on Dr. Lindig's diagnosis of degenerative disc disease of the lumbar and cervical spine. (EX-A, p. 143-4).

The Court finds that Dr. Lindig's records show that Claimant's degenerative disc disease was a pre-existing condition that contributed to her permanent total disability. The Employer was constructively aware of the condition because of the existence of Claimant's 1992 medical records. The Claimant's disability was made worse by her pre-existing condition, the nature of which caused each injury to her back to decrease her functional capacity. Accordingly, we find that the award of relief under section 8(f) is appropriate.

ORDER

1. Employer shall pay Claimant compensation for temporary total disability from February 27, 1994 until February 27, 1994, from November 9, 1994 until December 20, 1994, from and from April 13, 1996 until August 6, 1996. Compensation shall be based on an average weekly wage of $261.10;

2. Employer shall pay Claimant compensation for permanent total disability from February 29, 1996, the date of Maximum Medical Improvement until March 1, 1998, 104 weeks after the date of maximum medical improvement, based on an average weekly wage of $261.10;

3. Employer's request that they be granted Section 8(f) relief commencing March 1, 1998 is hereby GRANTED. Section 8(f) relief is granted to Employer to relieve Employer of any liability for disability benefits 104 weeks after the February 29, 1996 maximum medical improvement date;

4. Employer shall pay for or reimburse Claimant for all necessary and reasonable medical care and treatment related to her work-related injury and aggravations;

5. Employer is entitled to credit for any compensation paid to Claimant for the above noted periods;

6. Employer shall pay Claimant interest on any accrued unpaid compensation benefits. The rate of interest shall be calculated at a rate equal to the coupon issue yield equivalent (as determined by the Secretary of the Treasury) of the average auction price for the last auction of 52 week United States Treasury Bills as of the date this Decision and Order is filed with the District Director;

7. Claimant's counsel, James M. Hackett, shall have 20 days from receipt of this Order in which to file an attorney fee petition and simultaneously serve a copy of the petition on opposing counsel. Thereafter, Employer shall have 20 days from receipt of the fee petition in which to respond to the petition.

So ORDERED.

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RICHARD D. MILLS
Administrative Law Judge

RDM/ct